Governor's Council on Substance Abuse Report
Implementation of Initiative 692 The Washington Medical Use of Marijuana Act

Dr. Priscilla Lisicich, Council Chair
Dr. Carol A. Owens, Staff Coordinator

January 2000

WASHINGTON STATE
COMMUNITY, TRADE AND
ECONOMIC DEVELOPMENT
Building Foundations for the Future

Martha Choe, Director

Busse Nutley, Assistant Director for Community Development

GOVERNOR'S COUNCIL ON SUBSTANCE ABUSE

MISSION:

It is the mission of the Governor's Council on Substance Abuse to reduce substance abuse in Washington State.

This includes reducing the abuse of alcohol, tobacco, drugs, and other materials that individuals may abuse, including over-the-counter medications, gasoline, and glue.

VALUES:

We will work collaboratively while also recognizing diversity, combining efforts in the private, public, tribal, and nonprofit sectors.

Whenever possible, we will build on and strengthen effective structures, systems, and organizations that are addressing substance abuse, rather than develop new programs.

We will develop balanced and accountable strategies for reducing substance abuse, not emphasizing one approach over another, but recognizing that a complex set of problems requires more than one method of resolution.

RESPONSIBILITIES

The Governor's Council on Substance Abuse will:

Develop recommendations, based on community and agency input and involvement, for state and local strategies on substance abuse;

Advise the Governor on substance abuse issues;

Review and develop recommendations regarding state, local, and federal funding of substance abuse programs;

Advise the Family Policy Council on substance abuse issues through a collaborative process; and,

Provide policy recommendations to state agencies on alcohol, tobacco, and other drug issues.

GOVERNOR'S COUNCIL ON SUBSTANCE ABUSE REPORT
IMPLEMENTATION OF INITIATIVE 692 THE WASHINGTON MEDICAL USE OF MARIJUANA ACT

Department of Community, Trade and Economic Development
Local Government Division
Steve Wells, Assistant Director

Prepared by

Dr. Priscilla Lisicich, Council Chair
Dr. Carol Owens, Staff Coordinator

January 2000

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For more information, please contact the Governor's Council on Substance Abuse at (360) 753-5626. To receive additional copies of this report contact the Washington Substance Abuse Clearinghouse, 3700 Rainier Avenue South, Suite A, Seattle, WA 98144, or phone (206) 725-9696.

GOVERNOR'S COUNCIL ON SUBSTANCE ABUSE

WASHINGTON STATE COMMUNITY, TRADE AND ECONOMIC DEVELOPMENT — BUILDING FOUNDATIONS FOR THE FUTURE

January 15, 2000

The Honorable Gary Locke
Governor, State of Washington
Legislative Building
Post Office Box 40002
Olympia, Washington 98504-0002

Dear Governor Locke:

I am pleased to forward to you the results of a 1999 policy study on issues related to the Implementation of Initiative 692 (Washington Medical Use of Marijuana Act) that currently impacts the residents of the state of Washington.

The Council undertook this study to provide a more in-depth analysis for your use, and for use by others interested in the impacts of drug abuse policy in Washington State. We see this as a crucial issue facing all communities in Washington State.

In summary, the Council would like to recommend the following for your consideration:

- Resolve ambiguity in the definition of "a 60-day supply" of medical marijuana and the means intended for identification of legitimate users and care-givers by law enforcement
- Bolster existing prevention programs to communicate the dangers of marijuana use
- Track the consequences of the Initiative by collecting accurate data
- Increase the capacity to treat youth marijuana abusers
- Explore the conflict between Federal Workplace Laws and the Medical Marijuana Initiative.

We sincerely hope the information provided by this policy study will be of use to you and your office in dealing with current policy regarding the implementation of Initiative 692. Please contact me or Council staff if you need additional information or assistance during your consideration of these recommendations.

Sincerely,

Priscilla Lisicich, PhD
Council Chair

cc: Dick Van Wagenen, Governor's Executive Policy Office
Marty Brown, Director, Office of Financial Management
Busse Nutley, Deputy Director for Community Development, CTED

GOVERNOR'S COUNCIL ON SUBSTANCE ABUSE

LONG-TERM GOALS FOR REDUCING SUBSTANCE ABUSE

PREVENTION

1. Prevent and reduce the misuse and abuse of alcohol, tobacco, and other drugs.

2. Focus on outcome-based prevention strategies to increase the effectiveness of prevention efforts.

3. Increase the community ownership and responsibility for prevention of misuse of alcohol, tobacco, and other drugs.

TREATMENT

1. Increase access to and availability of chemical dependency treatment, as clinically necessary.

2. Reduce the negative effects of alcohol, tobacco, and other drugs.

3. Address the basic needs of people in chemical dependency treatment.

LAW AND JUSTICE

1. Increase public safety.

2. Increase the effectiveness of law and justice efforts to reduce alcohol and other drug abuse-related crimes.

3. Foster citizen involvement and support for effective law and justice efforts, including community-oriented policing.

EXECUTIVE SUMMARY

In November 1998 the voters of Washington State approved Initiative 692, allowing people suffering from specific medical conditions to use marijuana if approved by their physician. The non-specific provisions of the Initiative could lead to contentious court battles, inconsistent enforcement, and unclear messages to youth concerning the use of marijuana.

Issues Include

Federal law does not allow the medical use of marijuana.
The state Initiative does not protect medical marijuana users from federal sanctions.

State law only allows supply via patient-grown marijuana.
Patients unable to grow their own marijuana, or who need it sooner than growing allows, can only obtain marijuana from illegal sources.

Physicians recommending marijuana may be penalized by the federal government.

The current law does not define a "60-day supply" of marijuana.

Law enforcement may not be able to promptly verify the legitimacy of a claim of marijuana possession for medical use.

The perception that "marijuana is a medicine" may lead to increased marijuana use, although substantiating research is not available at this time.

Council Implementation Recommendations

Recommendation #1: Initiative Implementation Rule-making
After consideration of the issues, it is clear that implementation of the Initiative is frustrated by ambiguity in key terms. The Council recommends that the Legislature resolve ambiguity in the definition of:

- A "60-day supply" of medical marijuana; and

- The means intended for identification of legitimate users and caregivers by law enforcement.

Recommendation #2: Communicate the Dangers of Marijuana Use
The perception that "marijuana is a medicine" may lead to a decreased perception of harm, which has been shown to increase youth substance use. To prevent an increase in youth marijuana use, existing prevention programs should be bolstered to educate youth on the increased risk of dependence, lung cancer, lung damage, and poor pregnancy outcomes associated with chronic marijuana smoking.

Recommendation #3: Track the Consequences of the Initiative
To ensure that the full consequences of the Initiative are understood, accurate data should be collected on:

- How many youth are using marijuana and their perception of harm. This could be done via an increase in the number of schools surveyed by the Adolescent Health Behaviors Survey (currently only administered to a portion of Washington's youth) and the addition of a question on whether youth feel that marijuana is less harmful due to its use as a medicine;

- The number of youth seeking treatment for marijuana abuse;

- The number of medical marijuana users and their caregivers; and

- The instances of a "medical marijuana" defense being used in the courts, and the outcomes of those cases.

Recommendation #4: Increase the Capacity to Treat Youth Marijuana Abusers
Marijuana is already the drug of choice among youth admitted for treatment, surpassing even alcohol. Existing treatment backlogs for youth with marijuana problems may increase if youth marijuana use increases.

To address this potential increase in adolescents needing treatment for marijuana, funding for youth treatment should be increased.

Recommendation #5: Explore the Conflict Between Federal Drug-Free Workplace Laws and the Medical Marijuana Initiative
Ask the Attorney General for a legal opinion concerning the medical use of marijuana by an employee working for an employer governed by Federal workplace laws.

GOVERNOR'S COUNCIL ON SUBSTANCE ABUSE REPORT

Implementation of Initiative 692 – The Washington Medical Use of Marijuana Act

Introduction

In November 1998 the voters of Washington State approved Initiative 692, the Washington Medical Use of Marijuana Act.[1] The non-specific provisions of the Initiative could lead to contentious court battles, inconsistent enforcement, and unclear messages to youth concerning the use of marijuana. This paper is an attempt to describe the issues and propose solutions to avoid implementation problems.

Description of Initiative

The initiative allows persons suffering from the following conditions to use marijuana if recommended by a physician:

- Cancer;
- HIV;
- Multiple Sclerosis;
- Epilepsy or other Seizure Disorders;
- Spasticity Disorders;
- Intractable Pain, unrelieved by standard medical treatments;
- Glaucoma; and
- Debilitating Crohn's Disease unrelieved by standard treatments or medications (added by the Medical Quality Assurance Commission, November, 1999).[2]

Additional medical conditions can be added by the Washington State Medical Quality Assurance Commission.

To use marijuana, the patients are required to have written documentation from their physician stating that the health benefits would outweigh the health risks for the patient.

Patients are not allowed to possess more than a 60-day supply of marijuana.

Primary Caregivers

Patients are allowed to designate, in writing, a primary caregiver who is allowed to possess marijuana for use by the patient. The primary caregiver is not allowed to use marijuana.

To qualify as a primary caregiver, the person has to be responsible for the housing, health, or care of the patient. Primary caregivers can only assist one patient at any one time.

Potential Implementation Issues

The law as written presents a number of unresolved issues that may require legislative changes, state agency rule-making, court rulings, and policy changes to address.

Patient and Caregiver Implementation Issues

Federal law contradicts the state Initiative. Federal law does not allow the possession, distribution, or production of marijuana, unless a specific exemption is granted for research purposes.

State law only allows supply via patient-grown marijuana. The Initiative allows the patient or caregiver to grow marijuana. However, since caregivers are only allowed to serve one patient at a time, a centralized supply system (e.g., "marijuana buyers clubs") cannot be set-up. Patients unable to grow their own marijuana, or who need it sooner than growing allows, can only obtain marijuana from illegal sources.

Physician Implementation Issues

Recommending marijuana may be illegal under federal law. The U.S. Justice Department has threatened to revoke physicians' authority to dispense prescription drugs and exclude them from participation in Medicare and Medicaid if they recommend the use of marijuana.[3] However, there is some debate as to whether these sanctions would violate physicians' First Amendment right to communicate with their patients. No physician has been sanctioned by the federal government for recommending the use of marijuana.

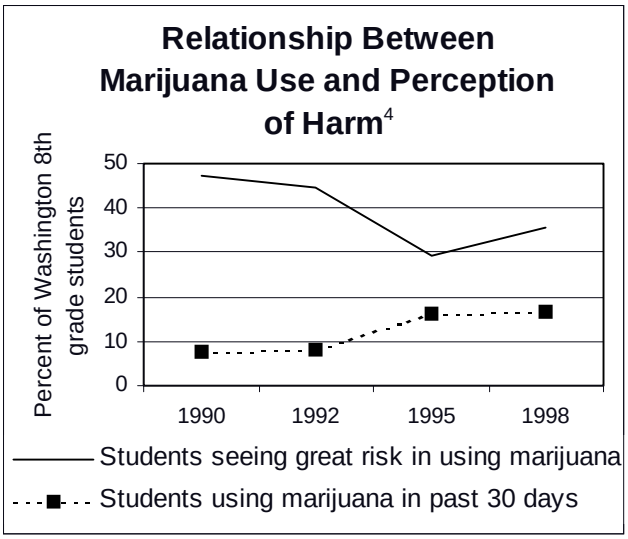
Law Enforcement Implementation Issues

The current law does not define a "60-day supply" of marijuana. Law enforcement may have difficulty determining if the "60-day supply" provision is being violated by persons they encounter possessing marijuana with a physician's permission.

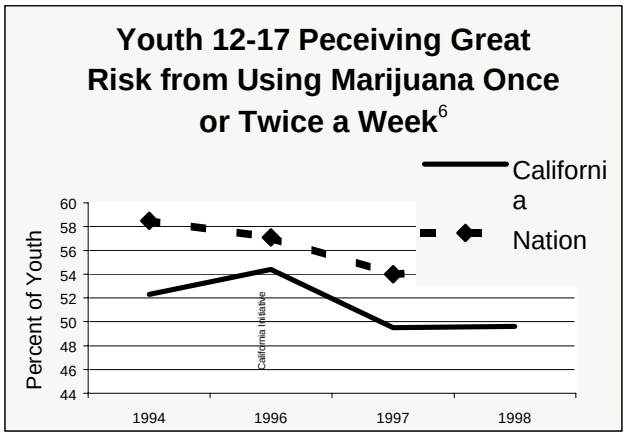
Law enforcement may not be able to promptly verify the legitimacy of a claim of marijuana possession for medical use. When law enforcement encounters a person in possession of marijuana who claims to have a physician's recommendation, it is unclear what action they should take. Currently there is no system for verifying written recommendations.

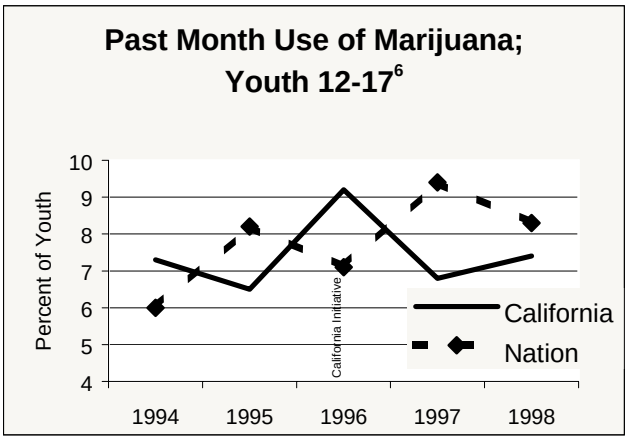
Should law enforcement accept written recommendations at face value, or should they verify that the physician is licensed and has approved marijuana use for the person possessing marijuana? If the recommendation cannot be verified, should the marijuana be seized, or should the person be allowed to keep the marijuana until the validity of the recommendation is determined? If the marijuana is seized, should it be returned if the recommendation is proven to be valid, even if this violates federal law?

The perception that "marijuana is a medicine" may lead to increased marijuana use. The "community norm" that marijuana is a medicine may reduce the perceived harm of marijuana use. Historically, as perception of marijuana harm has gone down among youth, marijuana use has gone up. [4]



The Institute of Medicine (IOM) report examining this issue states "[T]here is broad social concern that sanctioning the medical use of marijuana might lead to an increase in its use among the general population. At this point there are no convincing data to support this concern. The existing data is consistent with the idea that this would not be a problem if the medical use of marijuana were closely regulated as other medications with abuse potential, but we acknowledge that there are no data that directly address this question."[5] [6]





Because the Initiative does not regulate marijuana like other medications, and data is lacking on the public perception implications of initiatives such as Washington's, the Initiative may lead to a general increase in marijuana use.

Legal History of Medical Marijuana in Washington State

1909 – Marijuana defined as "poison" by state law that can only be sold by a licensed pharmacist for medical use.[7]

1923 – Marijuana redefined as a "narcotic" under Washington law. Physician's prescription required to obtain marijuana for medical purposes.[8]

1937 – Federal Marijuana Tax Act imposes regulation and taxation on the medical use of marijuana.

1969 – Marijuana redefined as a "Dangerous Drug" by state law.[9]

1971 – Medical use of marijuana outlawed by state law, except when used as part of federally-sanctioned research.[10]

1979 – Washington Controlled Substances Therapeutic Research Act passed by the Legislature. Law directed the Board of Pharmacy to study the medical use of marijuana for reducing nausea associated with cancer chemotherapy and treating glaucoma. The program supported studies of smoked marijuana and the then experimental THC pill. The results were instrumental in proving the value of THC in pill form (dronabinal) for the treatment of nausea, which was approved for general use shortly after the conclusion of the program in 1981. [11]

1998 – Washington voters approve the medical use of marijuana with a physician's written recommendation.

Current Washington State Marijuana Laws

Initiative 692 exempts medical users and their caregivers from the following Washington State marijuana laws. Actual sentences are significantly lower than the maximum, and prosecutors sometimes reduce charges to "attempted" possession, manufacture, or delivery.

State Possession Penalties
Currently in Washington State the maximum penalty for first-time possession of less than 40 grams of marijuana is 90 days in jail and a $1,000 fine (a misdemeanor). Second and subsequent offences for possession of less than 40 grams can result in 180 days in jail and a $2,000 fine.[12] No data is kept on actual sentences for misdemeanor marijuana possession.

First-time possession of more than 40 grams under Washington law can result in a maximum penalty of 60 days in jail and a $1,000 fine. Under Washington's sentencing guidelines, prior felonies and other factors (e.g., felony committed near a school) can increase the penalty up to 29 months and a $2,000 fine. [13] Actual sentences for non-narcotic possession offences, which include other drugs such as methamphetamine, average 2.7 months.[14]

State Growing or Delivering Penalties
First-time manufacturing (growing) or delivering marijuana is a class C felony and can result in 90 days in jail and a mandatory $1,000 fine. Under sentencing guidelines, prior felonies and other factors can increase the penalty up to 68 months and a $2,000 fine.[15]

First-time offenders received an average sentence of 2.7 months in jail. Subsequent offences resulted in sentences averaging one year.[16]

Federal Law Unchanged

Washington's Initiative does not exempt medical marijuana users and their caregivers from federal marijuana laws. Actual sentences are considerably less than the maximum. In general, federal charges are only brought against high-level traffickers handling over 100 kilograms of marijuana.

Federal Possession Penalties
Criminal – The maximum penalty for possessing personal quantities of marijuana is one year in prison and a $1,000 fine[17]

Civil – Fine of up to $10,000 for possession of personal quantities of marijuana.[18]

Federal Growing or Distributing Penalties
The maximum penalty for distributing a "small amount of marijuana for no remuneration" is one year in prison and $1,000.[19]

Maximum first-time federal penalties for growing or distributing less than 50 kilograms of marijuana, or growing less than 50 plants, is five years in prison and a $250,000 fine.[20]

Maximum first time penalty for growing 100 kilograms, or 100 or more plants regardless of weight, is five to 40 years in prison and a $2 million fine.[21]

1999 Legislative Proposals Related to the Initiative

Three legislative proposals related to medical marijuana were considered by the 1999 Legislature. None of the legislation was approved.

Allowing Initiative 692 Rule Making; SB 5704- Sen. Kohl-Welles
Would have granted the Department of Health rule-making authority to implement Initiative 692. During the Initiative campaign, some Initiative supporters incorrectly assumed that state agencies would have rule-making authority to define the provisions of the Initiative. Because this legislation modifies an Initiative, it would have needed a two-thirds affirmative vote from both houses of the Legislature to pass.

Requesting Federal Reclassification of Marijuana; SJM 8005 - Sen. Kohl-Welles
Would have asked the federal government to reschedule marijuana from Schedule I (dangerous, no medical use) to Schedule II (dangerous, has medical use).

Additions to Initiative; SB 5771-Sen. Hargrov
Would have required medical marijuana users to have doctor's documentation in immediate possession; 2) defined the elements of "valid documentation" (including a requirement that doctors define the allowable 60 day supply); 3) required doctors to

submit copy of documentation to the state Medical Quality Assurance Commission; and 4) allowed employers to remove medical marijuana users from their job if the marijuana use posed a safety risk or caused them to be unable to perform their duties.

Medical Marijuana Laws in Other States

Initiatives allowing the medical use of marijuana have been passed in five states in recent years. Although the provisions of other states' laws differ from Washington's, their experiences may provide some guidance to Washington's implementation efforts.

Alaska
In 1998 Alaska voters approved the medicinal use of marijuana for persons with a physician's permission. A confidential registry of patients approved to use marijuana will be maintained by the state.[22]

Arizona
Voters approved an initiative in 1996 allowing the medical use of all Schedule I (e.g. marijuana, heroin, LSD, etc.) drugs for medical purposes with a physician's recommendation. The law also reduced drug-law penalties and directed that people convicted on drug charges be released from prison. Arizona's legislature responded by passing a law requiring federal approval of marijuana for medical use. The legislature's modifications to the initiative were overturned by voters via a referendum in 1998.[23]

California
Voters approved an initiative in 1996 allowing the medical use of marijuana by patients with a recommendation from their physician. Marijuana dispensaries (often known as "buyers clubs") have been set-up in several cities to distribute marijuana to medical users, some under official charter of local governments.[24] Other cities and counties have issued identification cards to medical marijuana users, although no record is kept of who was issued cards.[25] Local authorities in some jurisdictions have arrested persons claiming medical possession of marijuana.[26] Federal authorities have closed some of the marijuana dispensaries.

A task force convened by California's attorney general has made the following implementation recommendations:

- A voluntary registry of medical marijuana users should be established;
- The California Department of Health should be given the power to determine what amount of marijuana is appropriate for a medical user;
- A regulated system of cooperative cultivation should be established; and
- The cases where medical marijuana use is authorized should be clarified and a patient's personal physician should be required to make the recommendation.

The task-force recommendations have not been implemented by the California state legislature.

Maine
Voters approved an initiative in 1999 allowing the medical use of marijuana for certain conditions if recommended by physician. The initiative:

- Limits the amount of marijuana that may be possessed for medical purposes to 1 ¼ ounces or less of harvested marijuana and a total of six plants, of which not more than three may be mature flowering plants;

- Requires medical marijuana users possessing marijuana to have available written documentation from their physician; and

- Allows the use of marijuana for medical purposes by a minor if their legal guardian gives written permission.

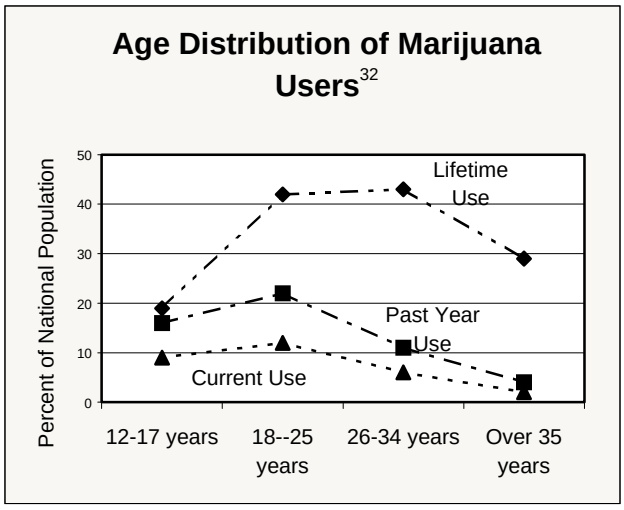
Nevada
In 1998 voters approved marijuana for medical use, but implementation depends on a second vote in the year 2000.[27]

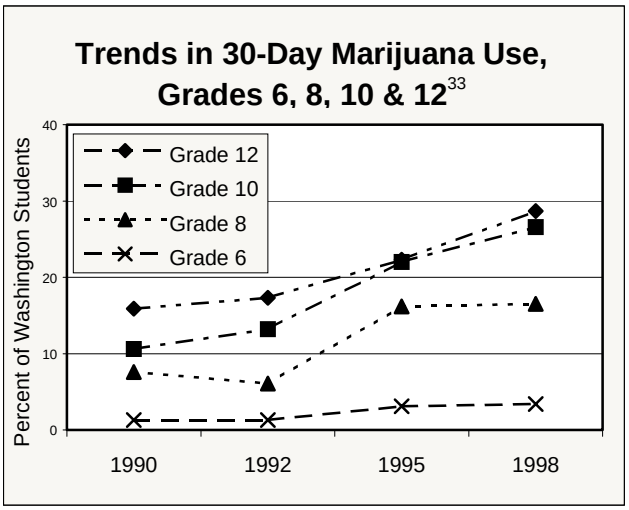
Oregon
In 1998 voters approved the medical use of marijuana when recommended by a physician. Oregon's law requires the state to create a medical marijuana user registration system, but does not require medical marijuana users to register to receive legal protection. Medical users are allowed to possess three mature plants, four immature plants, and one ounce of useable marijuana per mature plant.[28] Oregon officials estimate 500 marijuana users will register with the voluntary system, each paying $150 per year. It is estimated the registration system will cost $105,000 per year to operate.[29]

Washington, D.C.
Washington, D.C. voters voted in 1998 on a measure to allow the use of marijuana for medical purposes with a physician's permission. Although exit polls show the measure passed, Congress has blocked the city from counting the votes.[30]

Demographics of Marijuana Use and Addiction

Thirty-two percent of Americans have tried marijuana, and five percent are current users.[31 32 33]





Marijuana use has been increasing dramatically among youth in Washington State—more than a 150% increase in 10th grade use since 1990.

Drug	Percent of General Population Who Have Used Drugs	Percent of Users that Ever Became Addicted
Tobacco	76	32
Marijuana	46	9
Heroin	2	23
Cocaine	16	17
Anxiolytics (sedatives; hypnotic drugs)	13	9
Alcohol	92	15

Compared to most other drugs, dependence among marijuana users is relatively rare. Nine percent of marijuana users have experienced dependence. This may be due to differences in specific drug effects, availability of marijuana, or penalties associated with use.[34]

Consequences of Marijuana Use[35]

Some users of marijuana develop dependence. Risk factors for marijuana dependence are similar to those for other forms of substance abuse. People especially susceptible to marijuana addiction include adolescents, especially troubled adolescents, and people with psychiatric disorders (including substance abuse).

Chronic (regular) smoking of marijuana is associated with increased risk of cancer, lung damage, and poor pregnancy outcomes. These harmful effects may be associated with

the smoking of burning plant material, not the effects of the psychoactive substances in marijuana.

Acute (short-term) effects of marijuana use include diminished psychomotor performance, disrupted short-term memory, and in a minority of users unpleasant feelings. Marijuana use may cause short-term suppression of the immune system.

The Institute of Medicine report found that except for the harms associated with smoking, the adverse effects of marijuana use are within the range of effects tolerated for other medications.

Medical Use of Marijuana

Legal drugs, many very effective, already exist to treat medical conditions that may be alleviated by using marijuana. However, some patients develop adverse reactions or are non-responders to existing therapies. For this minority of patients, the medical use of marijuana may be useful.[36]

The IOM Report found that cannabinoid (found in marijuana) drugs indicate potential therapeutic value for pain relief, control of nausea and vomiting, and appetite stimulation. Data supporting cannabinoid use to treat muscle spasticity is weaker, but moderately promising. The least promising use of cannabinoids is to treat movement disorders, epilepsy, and glaucoma.[37]

The National Institute of Health report found enough evidence of efficacy to support further study of marijuana in treating loss of appetite, nausea and vomiting, neurological and movement disorders (i.e., epilepsy; multiple sclerosis), pain relief, and glaucoma.[38]

Problems with Smoked Marijuana
"Although marijuana smoking delivers THC and others cannabinoids to the body, it also delivers harmful substances, including most of those found in tobacco smoke. In addition, plants contain a variable mixture of biologically-active compounds and cannot be expected to provide a precisely defined drug effect. For those reasons, there is little future in smoked marijuana as a medically-approved medication," says the IOM report.[39]

The IOM report recommends the development of non-smoked, rapid onset delivery system for cannabinoid drugs. Until non-smoked, fast-acting cannabinoid drugs are developed, the IOM report makes the following recommendations:[40]

Short-Term Users of Smoked Medical Marijuana
Short-term use of smoked marijuana (less than six months) for patients with debilitating symptoms such as intractable pain or vomiting must meet the following conditions:

- Failure of all approved medications to provide relief has been documented;
- Symptoms can reasonably be expected to be relieved by rapid-onset cannabinoid drugs;

- Such treatment is administered under medical supervision in a manner that allows for assessment of treatment effectiveness; and involves
- An oversight strategy comparable to an institutional review board process that could provide guidance within 24 hours of a submission by a physician to provide marijuana to a patient for a specified use.

Long-Term Users of Smoked Medical Marijuana
The IOM report says "Until a non-smoked, rapid-onset cannabinoid drug delivery system becomes available, we acknowledge that there is no clear alternative for people suffering from chronic conditions that might be relieved by smoking marijuana, such as pain or AIDS wasting." The IOM reports goes on to recommend that chronic users be fully informed that they are using a harmful drug delivery system, that their condition is closely monitored, and that oversight is provided by a institution review board.

Development of Additional Cannabinoid Drugs

The currently legal THC capsule (dronabinol, commercially known as Marinol©) hampers its effectiveness due to slow absorption and patient desire for more control over dosing.[41] There may be other compounds in the marijuana plant that have useful therapeutic properties, and the THC in smoked marijuana may produce different drug effects than oral THC.[42] Because of current drug deficiencies and the potential medical uses of cannabinoids, both the IOM Report and a National Institute of Medicine have recommended the development of rapid-onset, reliable and safe delivery systems for cannabinoid drugs.[43] [44]

New Forms of Currently Legal THC
To address the delayed onset and titration (dose adjustment) deficiencies of the currently legal cannabinoid, oral THC, new rapid-onset routes of administration are being studied by the drug company Unimed. Rapid onset formulations being studied include a deep lung aerosol, nasal spray, nasal gel, and a sublingual (under tongue) preparation.[45]

Marijuana and Cannabinoids in Marijuana
Commercial interest in bringing marijuana or cannabinoids found in the plant to market appear to be nonexistent, according to the IOM Report. "Cannabinoids in the plant are automatically placed in the most restrictive schedule of the Controlled Substances Act, thereby serving as a significant deterrent to development. The plant itself is not only subject to the same scheduling strictures as are individual plant cannabinoids, but development of marijuana is also encumbered by a constellation of scientific, regulatory, and commercial impediments to availability."[46]

Synthetic Cannabinoids Not Found In Marijuana
The prospects are unclear for development and commercial availability of new cannabinoids not found in the marijuana plant. Cannabinoid drugs may be developed for the lucrative pain-relief market, given the need for less addictive, safer, easier to use, and more effective drugs for chronic pain.[47]

Actions Taken to Implement Legislation

Development of Standardized Procedures for Physicians and Patients
The Washington Chapter of the American Medical Association has developed a medical marijuana recommendation form for use by physicians. A guide describing the Initiative and its practical implications has been developed by the Washington Citizens for Medical Rights (the Initiative sponsor) and the American Civil Liberties Union of Washington. A Harborview HIV/AIDS clinic developed a draft policy regarding the recommendation of marijuana for medical use. A task force has been created to create guidelines for physicians throughout the Harborview-University of Washington medical system.[48]

Council Recommendations

Recommendation #1: Initiative Implementation Rule-making

After consideration of the issues, it is clear that implementation of the Initiative is frustrated by ambiguity in key terms. The Council recommends that the Legislature resolve ambiguity in the definition of:

- A "60-day supply" of medical marijuana; and
- The means intended for identification of legitimate users and caregivers by law enforcement.

The rule-making process should include all interested stakeholders, including the Washington Medical Association, the Washington Association of Sheriffs and Police Chiefs, the Washington Association of Prosecuting Attorneys, and supporters of the Initiative.

Recommendation #2: Communicate the Dangers of Marijuana Use

The perception that "marijuana is a medicine" may lead to a decreased perception of harm, which has been shown to increase youth substance use. To prevent an increase in youth marijuana use, existing prevention programs should be bolstered to educate youth on the increased risk of dependence, lung cancer, lung damage, and poor pregnancy outcomes associated with chronic marijuana smoking.

Recommendation #3: Track the Consequences of the Initiative

To ensure that the full consequences of the Initiative are understood, accurate data should be collected on:

- How many youth are using marijuana and their perception of harm, via an increase in the number of schools surveyed by the Adolescent Health Behaviors Survey (currently only administered to a portion of Washington's youth), and the addition of a question on whether youth feel that marijuana is less harmful due to its medical use;
- The number of youth seeking treatment for marijuana abuse;

- The number of medical marijuana users and their caregivers; and

- The instances of a "medical marijuana" defense being used in the courts, and the outcomes of those cases.

Recommendation #4: Increase the Capacity to Treat Youth Marijuana Abusers
Marijuana is already the drug of choice among youth admitted for treatment, surpassing even alcohol.[49] Existing treatment backlogs for youth with marijuana problems may increase due to the message sent by the Initiative.

To address this potential increase in adolescents needing treatment for marijuana, funding for youth treatment should be increased.

Recommendation #5: Explore the Conflict between Federal Workplace Laws and the Medical Marijuana Initiative
Ask the Attorney General for a legal opinion concerning the medical use of marijuana by an employee working for an employer governed by Federal workplace laws.

Endnotes

[1] Act was approved with a 59 percent yes vote; 62 percent of registered voters voted, according to the Washington State Secretary of State, www.wa.gov/sec/elections/gen98.htm. Supporters of the Initiative (Citizens for Medical Rights) spent $786,310; the opposition (We Said No!) spent $15,810, according to the Washington State Public Disclosure Commission, pdc.wa.gov/wa98/graph.html.
[2] State of Washington Department of Health Medical Quality Assurance Commission, Final Order on Petition for Inclusion of Crohn's Disease as Terminal or Debilitating Condition Under RCW 69.51A, November 5, 1999.
[3] New England Journal of Medicine, August 7, 1997, Volume 337, Number 6, pgs. 436-437.
[4] 1998 Washington State Survey of Adolescent Health Behaviors, Office of Superintendent of Public Instruction, Department of Social and Health Services, Department of Community, Trade and Economic Development. p. 56.
[5] "Marijuana and Medicine: Assessing the Science Base," Institute of Medicine, National Academy Press, Washington, D.C. 1999, p. 3.49.
[6] National Household Survey on Drug Abuse, Substance Abuse and Mental Health Services Administration, www.health.org/pubs/nhsda/98hhs/findings/.
[7] Revised Code of Washington, Section 8459, 1909.
[8] Laws of 1921, 1923; Notes to 126 Washington Reports; Narcotics 4071, p. 3146.
[9] Revised Code of Washington, 69.33, 1963.
[10] Revised Code of Washington, 69.50, 1971.
[11] "Implementation of the Controlled Substances Therapeutic Research Act, Report to the Governor and 47th Legislature," February 11, 1981, Washington State Board of Pharmacy.
[12] Washington State RCW 69.50.401.
[13] Adult Sentencing Guidelines Manual 1998, State of Washington Sentencing Guidelines Commission, pgs. III-224.
[14] Sentencing Guidelines Commission, 1998 statistics.
[15] Adult Sentencing Guidelines Manual 1998, State of Washington Sentencing Guidelines Commission, pgs. III-212, III-213.
[16] Sentencing Guidelines Commission, 1998 statistics.
[17] 21 USCS Sections 844 (1996).
[18] 21 USCS Sections 844a (1996).
[19] 21 USCS Sections 841, 844 (1996).

[20] 21 USCS Sections 841 (1996).
[21] 21 USCS Sections 841 (1996).
[22] Alaska Division of Elections, www.gov.state.ak.us/ltgov/elections.
[23] Arizona Secretary of State, www.sosaz.com/election/1998/General/Canvass1998GE.pdf
[24] The City of Oakland sanctioned the creation of a medical marijuana buyers cooperative that was closed by federal officials. Oakland also adopted a policy allowing medical marijuana users to possess a three-month supply of marijuana, which is defined as: Particle form: One and one-half pounds, or six pounds if the patient grew the marijuana; Plants: Forty-eight indoor plants if they are flowering; no more than 96 indoor plants if less than 48 are flowering. Thirty outdoor plants if they are flowering; no more than 60 plants if less than 30 are flowering. No more than 144 total indoor and outdoor plants, provided that the flowering plants limits are not exceeded. City of Oakland Police Services Policy, 1999.
[25] "For Medicinal Purpose Only – City's Police Chief Back Limited Use of Marijuana," *Seattle Times*, Seattle, Washington, April 11, 1999, section A, p. 8.
[26] "Police Return Pot to Man Using it to Alleviate Pain," *The Oregonian*, Portland, Oregon, April 25, 1999, section A, p. 20.
[27] Nevada Elections Division: sos.state.nv.us/nvelection/1998General/98o_results_msw97.pdf
[28] "Recommendations of the Attorney General's Work Group on Medical Marijuana," www.doj.state.or.us/medmar.htm.
[29] "Medical Marijuana Card Will Cost $150 Per Year," *The Oregonian*, Portland, Oregon, May 1, 1999, p. A1.
[30] "5 States Vote Medical Use of Marijuana," *New York Times*, New York, New York, November 5, 1998, Section B, p. 10.
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[32] Marijuana and Medicine: Assessing the Science Base," Institute of Medicine, National Academy Press, Washington, D.C. 1999, p. 3.13.
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[42] "Potential Medical Uses of Marijuana," National Institute of Health, February 1997, p. 2.
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